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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER: 11-25 | 2. STATE Nebraska |
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE July 1, 2011 | |

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN
 AMENDMENT TO BE CONSIDERED AS NEW PLAN
 AMENDMENT

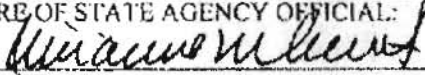
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

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| 6. FEDERAL STATUTE/REGULATION CITATION: | 7. FEDERAL BUDGET IMPACT: a. FFY 2011 \$(19,471) b. FFY 2012 \$(77,882) |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Item 3, page 2 Attachment 4.19-B, Item 4b, page 1 Attachment 4.19-B, Item 6a, page 1 Attachment 4.19-B, Item 6b, page 1 Attachment 4.19-B, Item 12d | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Item 3, page 2 Attachment 4.19-B, Item 4b, page 1 Attachment 4.19-B, Item 6a, page 1 Attachment 4.19-B, Item 6b, page 1 Attachment 4.19-B, Item 12d |


10. SUBJECT OF AMENDMENT:
Laboratory fee schedule reduction.

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT
 OTHER, AS SPECIFIED: Governor has waived review
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

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| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | 16. RETURN TO: Patricia (Pat) Taft Division of Medicaid & Long-Term Care Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509 |
| 13. TYPED NAME: Vivianne M. Chaumont | |
| 14. TITLE: Director, Division of Medicaid and Long-Term Care | |
| 15. DATE SUBMITTED: August 10, 2011 | |

FOR REGIONAL OFFICE USE ONLY

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| 17. DATE RECEIVED: August 10, 2011 | 18. DATE APPROVED: March 6, 2012 |
| PLAN APPROVED -- ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2011 | 20. SIGNATURE OF REGIONAL OFFICIAL:  |
| 21. TYPED NAME: James G. Scott | 22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations |
| 23. REMARKS: | |